MDR Tracking Number: M5-04-3890-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 07-13-04.

The IRO reviewed therapeutic exercises, electric stimulation unattended, supplies and materials, neuromuscular reeducation, patient evaluation and therapeutic procedures group rendered from 10-16-03 through 12-02-03 that were denied based upon "U".

The IRO determined that therapeutic exercises, electric stimulation unattended, supplies and materials, neuromuscular re-education, patient re-evaluation and therapeutic procedures-group from 10-16-03 through 11-20-03 **were** medically necessary. The IRO determined that therapeutic exercises, electric stimulation unattended, supplies and materials, neuromuscular re-education, patient re-evaluation and therapeutic procedures-group from 11-24-03 through 12-02-03 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-09-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97001 date of service 10-14-03 denied as "K" (not applicable healthcare provider). The services rendered are within the scope and practice of the provider rendering the service. Reimbursement of $85.45 per the Medical Fee Schedule effective 08-01-03 is recommended.

**ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 10-14-03 through 11-20-03 in this dispute.

This Findings and Decision and Order are hereby issued this 7th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh


# Envoy Medical Systems, LP
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**Austin, Texas 78758**

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**IRO Certificate #4599**


**NOTICE OF INDEPENDENT REVIEW DECISION**

October 5, 2004

**Re: IRO Case # M5-04-3890**

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed in Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits
3. MDR request 7/8/04
4. Letter of medical necessity 5/28/04
5. Medical review 8/23/03
6. Comprehensive medical analysis 8/26/03
7. Employers first report of injury ___
8. Work hardening notes
9. TWCC work status reports
10. Daily therapy notes
11. Active rehab exercise / fee slips
12. Electrodiagnostic study report 7/18/03
13. Initial exam report 5/17/03
14. FCE reports 6/27/03, 7/25/03, 8/11/03
15. Job analysis
16. Program policies and other records from treatment facility
17. MRI lumbar spine report 5/29/03
18. Radiological report lumbar spine 5/21/03
19. Exam forms from treatment facility
20. Physician notes

History

The patient injured her lower back in ___. She sought the care of a chiropractor, and was treated with chiropractic treatment, physical therapy and a work hardening program.

Requested Service(s)

Work hardening and work hardening each additional hour 7/15/03 – 8/6/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient had an adequate trial of conservative treatment prior to the disputed dates of service that failed to relieve her symptoms. She entered the work hardening program with a VAS of 4, and after six weeks of the program her VAS was only 3. On 8/6/03, the last date in this dispute, her VAS was still 4. Based on the patient's limited response to a supervised therapy program, a work hardening program was not indicated. The need for such a program is usually based on multidisciplinary needs and a good response to past treatment. The patient's ongoing and chronic care did not produce measurable or objective improvement, did not appear to be directed at progression for return to work, and was not provided in the least intensive setting.
According to the records provided for this review, the patient suffered a lumbar strain injury that should have responded well to appropriate chiropractic treatment. A work hardening program was not indicated or supported by the records provided, and it was not beneficial to the patient.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.